

File

**TRANSMITTAL AND NOTICE OF APPROVAL  
OF STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:  
00-008

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
10-1-00

5. TYPE OF STATE PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1920A of the Social Security Act

7. FEDERAL BUDGET IMPACT:  
a. FFY \$  
b. FFY \$

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 23c

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If applicable)

Attachment 2.2-A, page 23c.

10. SUBJECT OF AMENDMENT: Presumptive Eligibility for Children under age 19.

GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:  
Comments, if any, to follow.

11. SIGNATURE OF STATE AGENCY OFFICIAL:

12. TYPED NAME: Patricia A. Wilson-Coker

13. TITLE: Commissioner

14. DATE SUBMITTED:  
December 29, 2000

16. RETURN TO:

State of Connecticut  
Department of Social Services  
25 Sigourney Street  
Hartford, CT 06106-5033  
Attention: Robert Augeri

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
December 29, 2000

18. DATE APPROVED:  
March 23, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Ronald Preston

22. TITLE: Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Connecticut

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
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B. Optional Coverage other Than the Medically Needy  
(Continued)

\_\_\_\_\_ The following reasonable classifications of children described above who are under age \_\_\_\_\_ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

- |                         |  |
|-------------------------|--|
| 1902(e) (12) of the Act | <input checked="" type="checkbox"/> 21. A child under age 19 _____ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above. |
| 1920A of the Act        | <input checked="" type="checkbox"/> 22. Children under age 19 who are determined by a "qualified entity" (as defined in 1920A(b) (3) (A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.   |

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

TN No. 00-008  
Supersedes 98-009

Approval Date 3/23/01

Effective Date 10/1/00